ORIGINAL ARTICLE

Multiple dimensions of violence against healthcare providers in Karachi: Results from a multicenter study from Karachi

Lubna Ansari Baig,[1] Syeda Kauser Ali,[2] Shiraz Shaikh,[3] Maciej Maksymilian Polkowski[4]

Abstract

Objectives: To investigate the causes, consequences and possible solutions for violence against healthcare.

Methods: The qualitative study was conducted in Karachi June 2015 to December 2015 using in-depth interviews and focus groups discussions with all stakeholders. Transcription was done verbatim using both audio and videotapes of all the sessions. First open coding was done using inductive analyses by 3 researchers. After consensus, these codes were used for thematic content analysis. Interviews and discussions were stopped after saturation was reached and no new codes were identified.

Results: Overall, 42 in-depth interviews and 17 focus groups discussions were held. Major forms of physical violence included beating, throwing things, abusive language, threats, harassment, damage to building, furniture, vehicles and equipment. The threshold of violence was very high for verbal violence and minor forms of physical violence. The causes were identified as behavioural (communication gap between providers and patients, attendants), institutional (capacity, resources and systems) and socio-political (growing illiteracy and intolerance). The sequelae of violence included guilt, night dreams, shame and 61.9 % (N=26/42 IDIs)% who faced violence did not report it officially.

Conclusions: Violence faced by healthcare providers was multifaceted and needs interventions at varied levels, including training of healthcare staff in dealing with violence and its aftermaths, security measures at the healthcare institutions inclusive of ambulance services and policies at the national level to manage and de-escalate violence against healthcare.

Keywords: Healthcare, Violence, Qualitative research. (JPMA 68: 1157; 2018)

Introduction

Violence in megacities has always been an observed element and is one of the significant public health dilemmas. It is among the leading causes of death globally.[1] According to International Federation of Red Cross (IFRC), the basis of any violence is misuse of power.[2] Over the years, the occupational violence, especially in relation to healthcare professionals (HCPs) has emerged as a major threat to HCPs. HCPs are the working officials that are engaged in delivering health to the needy population within and outside the health facilities. They may be doctors, nurses, paramedic staff, allied health professionals, ambulance service providers, health workers, especially community workers etc. The 39th World Health Assembly specifically addressed the issue and agreed that HCPs are vulnerable to occupational violence ranging from blocking or interfering with timely access to care; discrimination in access to care, killing, injuring, kidnapping, harassment, threats, intimidation, and robbery to bombing, looting, forceful interference with the running of healthcare services.[3] Regrettably, there seems to be a misplaced community expectation that HCPs — as members of caring professions - should continue to provide care regardless of the risks they may face. Violence against HCPs has existed for a long time and condemned internationally. The developing countries have reported high incidence of physical and verbal violence in the emergency departments but that number is not even close to the proportions seen in Pakistan, particularly in Karachi, where it is a fairly common and to a certain extent acceptable phenomenon. The city has a profiled trend in relation to violence against HCPs. Over the years, several violent incidents have happened in which several innocent people lost their lives (and this does not include threats, verbal violence and extortions). The victims have ranged from doctors, nurses and healthcare workers etc. According to Pakistan Medical Association (PMA), an autonomous body that voices the issues of healthcare providers, there have been almost 128 doctors killed since 1995 till 2015 across Pakistan. The highest incidents happened in 2014, when around 18 deaths were reported.[4] A nationwide study conducted in 2009 in the emergency departments of major hospitals

[1,3]Institute of Public Health, Jinnah Sindh Medical University, [2]Agha Khan University, Karachi, [4]International Committee of Red Cross, Islamabad.

Correspondence: Lubna Ansari Baig. Email: lubna.shakil1983@gmail.com

reported that in the 2 months 76.9% of physicians had faced abuse (verbal or physical) from patients or their caretakers.[5] While quantitative studies have highlighted the burden of this problem, violence faced by HCPs is a complex issue that has many facets. Therefore, for an in-depth understanding of this major problem, the current study was planned to investigate the causes, consequences and solutions of this problem from multiple stakeholders. The ultimate aim was to identify strategies for preventing and de-escalating violence against HCPs.

Subjects and Methods

The qualitative study was conducted in Karachi from June 2015 to December 2015 using in-depth interviews (IDIs) and focus groups discussions (FGDs) with all stakeholders. Before developing the proposal of this phenomenological study design, one roundtable conference, several meetings and a workshop was organised with the stakeholders to identify and finalise the questionnaire. The stakeholders included representatives from hospitals, ambulance services, NGOs, law enforcement agencies (LEAs) and media persons.

Ethical approval was taken from the review committee of Pakistan Health Research Council (PHRC), institutional review board of JPMC, and all review boards of the individual institutions concerned.

The semi-structured questionnaire developed for IDIs and FGDs was tested during the training of data collectors who were MBBS faculty members of APPNA Institute of Public Heath (AIPH), Karachi. The interviewers included the first three authors and MBBS faculty members of AIPH did note-taking and video-taping. All IDIs and FGDs were done face-to-face and were video- and audio-taped. The interviewers guided the discussion, while one data collector recorded the interview on paper and another recorded the nuances of the discussion and managed the recording. Participants were selected through purposive sampling and informed consent was taken from all the participants, including all cadres of HCPs like doctors, nurses, paramedics, technicians, administrators, ambulance staff, media personnel and LEA representatives. Data was collected on site at 8 hospitals, 6 Media groups, 5 NGOs, 3 ambulance services and 2 LEAs.

Transcription was done verbatim using audio and video recordings and notes taken during data-collection. Translation was done by the professional transcriber and checked through notes by all the authors. Open coding of six transcripts was done by first three authors using inductive data analysis. Consensus was reached on five broad categories, including description of violence, acceptance of violence, causes of violence, sequelae of incidents of violence and recommendations. Sub-themes were identified for each of the broad categories and their frequency was noted to identify the common and relatively uncommon sub-themes. The rest of the transcripts were analysed deductively using the five major themes. No new themes emerged during deductive analyses and saturation was reached after 40 IDIs and 16 FGDs. Results were shared with the stakeholders in a large group meeting and no new dimensions were mentioned by any stakeholder. Data was coded and names were not used. Also, secrecy was maintained by adding a password and data was only accessible to the researchers.

Results

Overall, 42 IDIs were conducted that lasted between 45 and 60 minutes. There were 17 FGDs each of which lasted from 50 to 90 minutes and comprised a total of 130 subjects.

Major forms of physical violence described included beating, punching, slapping, fist-fighting, hitting, kicking, and throwing things like shoes, stones, etc. Abusive language and threats were regarded as major forms of verbal violence, while speaking in loud voice was also mentioned by some interviewees. Damage to building, furniture, vehicles and equipment was also described as violence by 71.4% (N= 30/42 IDIs) of participants. Among other forms of violence, harassment, using weapons, killing and extortion were reported by all 42 in IDIs and in all 17 FGDs while kidnapping and robbery/snatching was also mentioned by a 23% (N=10/42 IDIs). Beating and abusive language was predominantly the main forms of violence for HCPs, ambulance staff and media, while LEAs considered an act violent if it was cognizable; the explanation given by police was: "an act/incidence which leaves visible marks on the body". Also, snatching was reported by those who were involved in fieldwork like, ambulance staff and media.

There was general acceptance of HCPs and ambulance staff for verbal and even minor forms of physical offence. Acceptance for verbal abuse was reported more compared to acceptance for minor forms of physical violence. As expressed by Director, Emergency Department, of a government tertiary care hospital, "Now people do not consider verbal violence as violence at all. They are so acclimatised to verbal abuse that they

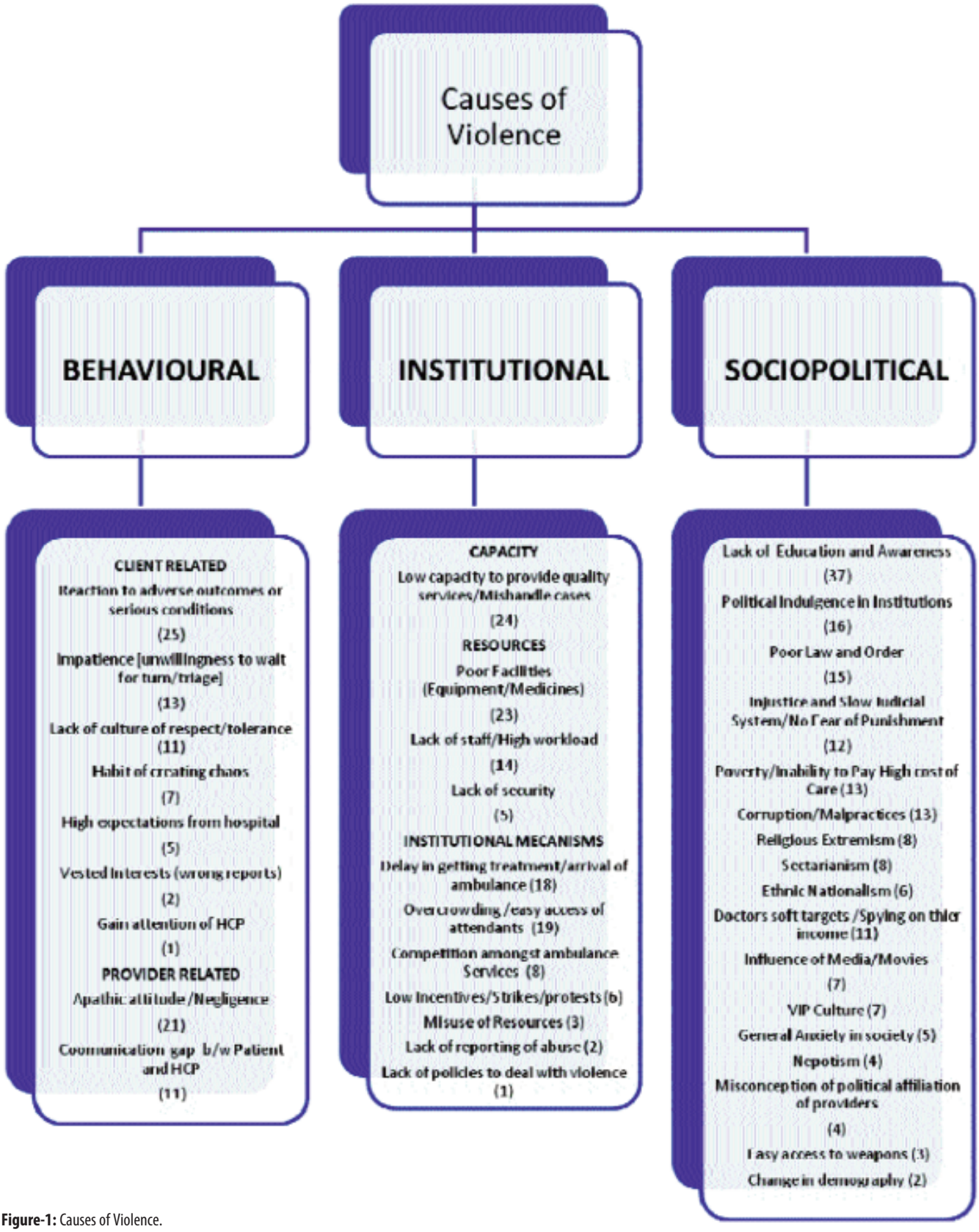

Figure-1: Causes of Violence.

do not even consider that it is any sort of violence". Main reasons for acceptance of violence included considering it patient's right or part of profession and fear of adverse consequences of reporting including threat to life or job. One of the doctors working at a government hospital said, "Even if they speak to us harshly then we have been trained to tolerate it"

Policemen reported tolerance among doctors for paying extortion money and reluctance to pursue lengthy procedures of investigation. One of the police officers said, "Doctors take relief by paying 2-3 lacs. By doing this they are not only doing wrong to themselves but also doing wrong to society"

Causes of violence were categorised as "behavioural", "institutional" and "socio-political" (Figure-1).

Behavioural causes were further sub-categorised into client and provider-related causes. Among the client-related causes, violence was predominantly seen as a natural reaction of adverse outcome or serious condition of the patients by all stakeholders.

Impatience and intolerance on the part of consumer were also seen as major behavioural reasons by HCPs. Other minor reasons included habit of creating chaos, high expectations from the hospitals and vested interests of the attendants, including expectation of getting wrong medical reports, As pointed out by a doctor, "Violence occurs when people get over-demanding without communicating their concerns to doctor". Ambulance drivers complained that attendants of patients don't listen to them "Attendants want that 4-5 of them should come with the patient in ambulance. We tell them to take 1-2 attendants but they don't listen".

On the part of providers, apathy, negligence and communication gap with the attendants were highlighted by media personnel and LEAs. One of the police officers said, "Violent issues arise when doctors do not give proper attention to patients. They have become earning machines."

Institutional causes were sub-categorised into capacity-related issues, resource constraints and institutional mechanisms. HCPs complained about lack of trainings on communication, counselling and de-escalation of violence. One of the nurses said, "It is our bad luck that we are not given any training for these situations. We judge and manage these situations according to our experience". Low capacity of HCPs to provide quality care and mishandling of cases was highlighted by participants from media and LEAs. A policeman complained, "Most of the hospitals and clinics do not meet the standard that they should".

Among resource constraints, lack of facilities, including equipment and medicines, lack of staff and high workload and low incentives leading to protests by HCPs were reported highly. One senior medical officer working in a government hospital said, "You know this is a government hospital and everything is not available here but attendants don't realise this". HCPs also complained about inadequate security staff and security facilities. A crime reporter, while commenting on facilities in ambulances, said, "Ambulances do not have any facility to save life; they are just carriers".

Among institutional mechanisms, overcrowding due to easy access of attendants inside the hospitals and delayed response in treatment or rescue were seen as major institutional reasons of violence. One of the staff nurses said, "When there are only 1-2 attendants with a patient then chances of violence reduce". In the field, delay in rescuing patients due to traffic was raised by ambulance staff, "Sometime it is not possible to reach the victim on time, especially in traffic hours. Then people fight with us." Media people also emphasised that delay was due to competition among ambulance services to take the patients. A journalist while raising this issue said, "I don't know what they want, but they fight over one dead body. Three organisations fight to place their sheet over the body". Lack of safety protocols and poor communication facilities were also emphasised by a few participants. One of the ambulance drivers expressed, "Sometimes the command and control staff does not know where we are."

Among socio-political causes, HCPs complained of poor law and order and easy access of weapons to public. One of the doctors complained, "Such are the conditions that people carry guns and walk freely in hospitals" One of the doctors while discussing the current law and order situation said, "A person is so uncertain and insecure that when he goes on the road he doesn't know if he will come back alive or not."

LEAs blamed slow prosecution in courts as a major deterrent to containing violence. As pointed out by a policeman,, "Weak Prosecution and absence of witness is the major reason for freedom of criminals." Other important factors highlighted by the participants included general lack of education and awareness in society. One of the community health supervisors commenting on misconception of people about polio

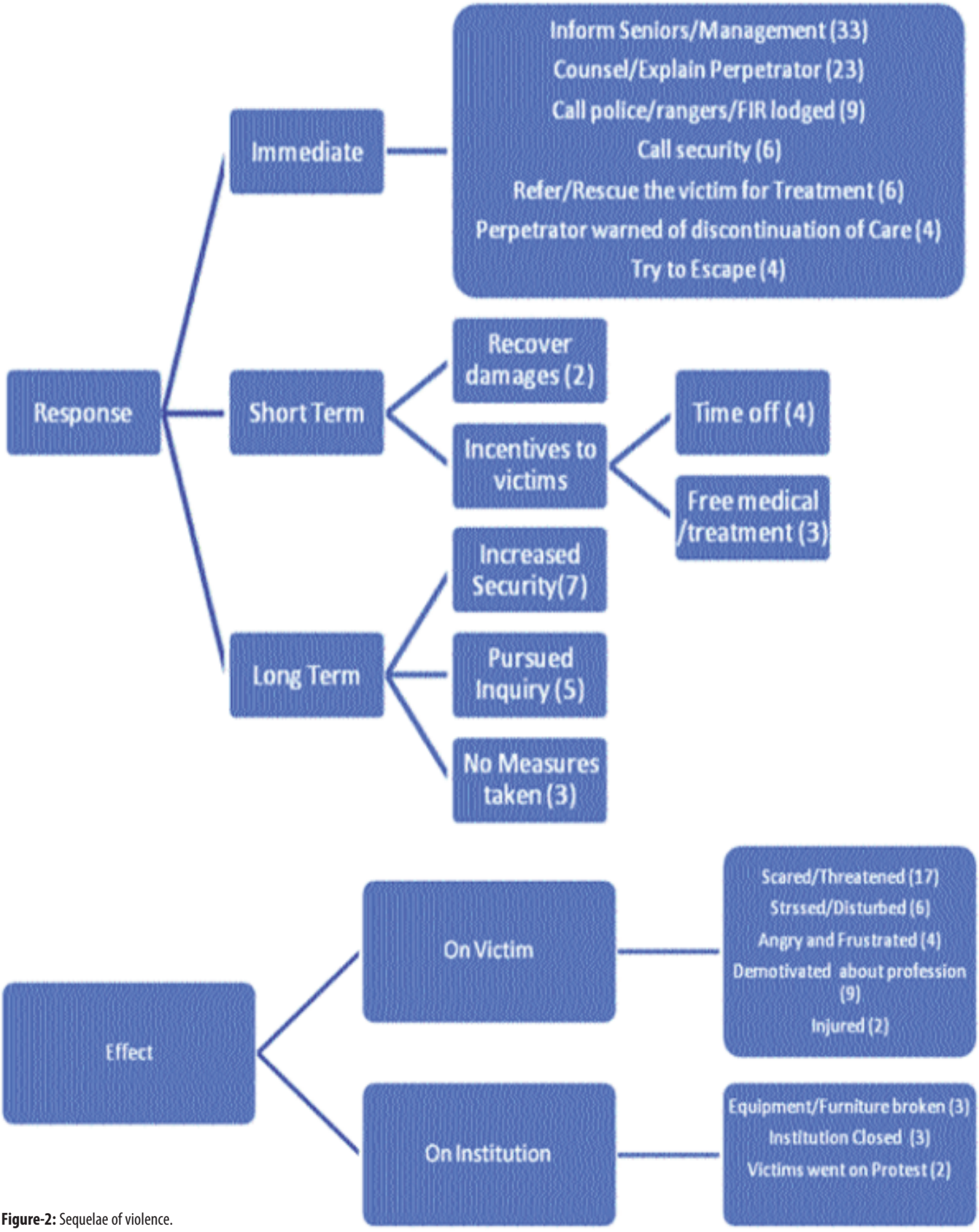

Figure-2: Sequelae of violence.

vaccines said, "They say we do not want to give polio to our children, they can die from it, it causes infertility so restricts family growth and we don't want polio". Poverty leading to inability to pay high cost of medical care was also raised as an important predictor of violent behaviour. Corruption in medical practice was also expressed as a reason by a policeman. "Why do doctors go to perform Umrah (pilgrimage) on the tickets provided by pharmaceutical companies and why do they ask them to put an airconditioner (AC) in their office". Some doctors also complained of negative role of media and LEAs in projecting negative image of HCPs. A postgraduate trainee said, "Media and police pictured us bad, we are not as bad as they show us on TV that patient died due to doctor's negligence but they do not show that patient had arrived in a critical condition".

The sequelae of violence were categorised as "response to violence" and "effect of violence" on victim and institution (Figure-2).

Reporting to the management or seniors and counselling the perpetrators were the two predominant immediate responses to violence that were reported by HCPs. One of the doctors working in emergency department of a government hospital said, "We have to choose who the intelligent person among them is? Who can mentally listen to us? If everyone is making noise, we cannot stand in between them and tell them. We will bring a single person to a side and will make them understand things". A staff nurse emphasised positive effect of counselling, "If you will counsel the patient's attendants and convince them, they will understand". Few HCPs pointed to calling the available security or LEAs and warning the perpetrators of discontinuation of care. Some of them mentioned escaping in such situations. Ambulance staff responded to such situations by informing control centre which provide them address of area's police station and their number. Media workers said that they tried their best not to disturb HCPs and LEAs while they were covering any event. A cameraman said, "We try to do our work without disturbing them". Policemen responded to violence by reaching the spot as soon as possible, helping to rescue the victims and tracking the criminal in the long run. Short-term response included recovering damages and provision of incentives to victims in a few cases. In the long run, increase in security measures and pursuance of inquiry was reported in a few instances while some participants complained of no response at all.

Violence affected the victims psychologically, made them scared and demotivated them at their job. A disappointed nurse said, "You are giving care to patient on the one hand and you have to listen to bad language from attendants on the other. This really makes me feel bad about my job." An ambulance driver expressed his fear by saying, "We feel scared when someone is shot. We try to take the victim to hospitals as soon as possible". Violence also leads to damage of institutional property and closure of institution in a few instances. A crime reporter also mentioned that violence not only affected HCPs but it also terrified other patients.

The recommendations to improve safety and security of HCPs, as reported by the participants, were also noted (Table). They were classified as institutional and societal.

Table: Recommendations.

A. Institutional	
Capacity and Resources	
Adequate Facilities (Equipment/Medicines/HCP's)	(26)
Training of HCP's in Communication/Counseling Skills	(24)
Increased security personal and facilities	(21)
Training in managing violence	(12)
Improved Clinical/Professional Skills of HCP's	(10)
Improved Job Conditions and Incentives for HCP's	(9)
Improved Staff coordination and teamwork among HCP's	(8)
Rules and Regulations	
Restricted access of attendants	(10)
Rules for Prompt Response/Triage	(6)
Regulate malpractices of HCP's	(5)
No access of weapon inside the hospitals	(4)
Policy on Violence	(2)
Complain Cells for Patients	(2)
HCP's should be allowed to keep weapons for protection	(1)
Institutional Liaisons	
Community Involvement	(8)
Inter-sectoral collaboration (Health/LEA/NGO s/Media)	(5)
B. Societal	
Awareness Campaigns	
Awareness of general behaviour to respect HCP's esp. Emergency	(10)
Awareness on Benefits of Polio Vaccine	(5)
Awareness for respecting law	(4)
Awareness to give way to Ambulances	(2)
Social Reforms	
Improve Performance of LEA's	(11)
Improve Judicial System and Prompt action against culprits	(8)
Decrease political involvement in Institutions	(7)
Improved literacy rate	(6)
Ban on Religious Hate speeches	(3)
Merit based Culture	(2)
Finish VIP culture	(1)
Role of Stakeholders	
Media should raise awareness and tell the truth	(16)
People, LEA's and Media should not interfere with rescue work	(3)
Clerics should spread the message of peace and unity	(2)
LEA's should support HCP's	(1)
Doctor Associations should highlight the issue related to violence	(1)

Institutional recommendations were sub-categorised as reforms required in improving resources, building capacity of HCPs and developing policies.

Improvement in availability of material and human resources (including equipment, medicines and HCPs) was highlighted by all stakeholders. A doctor in a public-sector hospital recommended, "Number of beds and number of wards should be increased." A policeman emphasised on adequately equipping the ambulances so that the serious patients may get the best care. Enhanced security facilities were highlighted by majority of participants. Another policeman talked about beefing up security in major hospitals by recommending, "Police check posts should be erected in all hospitals so that police can respond timely during violent incidents."

Training of HCPs in communication skills and de-escalation of violence was considered essential. As pointed by a senior, medical officer, "A training module should be developed in which you teach HCPs on how to deal with the violent attendants or violent individuals". Some of them also drew attention to improved professional skills of HCPs, job conditions and incentives of HCPs.

Among improvements needed in institutional rules and regulations, participants recommended restricted access of attendants inside the hospital, mechanism of "triage" and strict regulation of HCPs. A cameraman said, "Critical patients should be classified in A category and less serious ones in B category". Weapon-free policy in institution was also mentioned. In the field, need for a code of conduct about the role of HCPs, media persons and LEAs was also emphasised. An ambulance driver commented, "LEAs should restrict the media from reaching the crime site and taking critical pictures interfering in rescue work".

Societal recommendations were sub-categorised into "awareness campaigns", "social reforms" and "role of stakeholders". Need for improving awareness for respecting HCPs in emergency situations was highlighted particularly. General awareness on respecting law and benefits of polio vaccines was also recommended. In the field, awareness on giving way to ambulances and avoidance of interference in rescue work were particularly highlighted. An ambulance driver said, "If someone hears the siren, they should automatically leave the fast track".

Major social reforms recommended included improvement in the performance of LEAs, literacy rate, judicial system and reduction in political interference in institutions. Banning religious hate speeches were also recommended by a few.

About roles of different stakeholders, great emphasis was put on media to play a positive role in raising awareness and telling truth to people. One of the doctors said, "They should tell that violence against paramedics, doctors and nurses should not take place". Along with media, role of religious leaders was also thought to be important. A policeman said, "The ulema (vlerics), media and leaders should spread messages about patience and humanity". In emergency situations in the filed a coordinated response from HCPs, media persons and LEAs was recommended. As suggested by an ambulance driver, "We should all have coordination with media and other ambulance services. When there is coordination, there is less chaos".

Discussion

Although this is not the first study that has investigated violence against HCPs, it is unique as it has delved deep into the issue and has validated previous studies. Several quantitative studies have been conducted in different countries before,[5-14] nevertheless none of those studies has involved all the stakeholders that are directly or indirectly related to violence among HCPs. Qualitative approach has been used for the first time for exploring this issue which has yielded in-depth understanding of the problem.

High threshold for acceptance of violence was observed among all stakeholders interviewed.

HCPs considered workplace violence in medical profession as part of their job and patients' right while LEAs interpreted violence an act that is cognizable. Due to this high acceptance, violence is generally unreported. Reluctance to report was also found due to possible adverse consequences on their job or family life. Lack of reporting due to adverse consequences of reporting have also been reported in studies done in hospitals of Palestine and Saudi Arabia.[10,12] There is a need to change the perceptions of all stakeholders about violence and encourage zero tolerance for such events so that all forms of violence are reported. Further, appropriate action by management according to nature of the violence is also need of the hour. An interventional study in the past has shown improvement in reporting ability to deal with violence after the management recorded the violent events and provided structured feedback.[13]

Most important cause of violence was seen as

consequence of emotional reaction by attendants (less frequently by patients themselves) due to patient's serious conditions or adverse outcomes. Another more frequently mentioned reason was unreasonable expectations of the patients and attendants from healthcare institutions. Although emotional reaction is a natural response, interventions aimed at calming down the attendants through effective counselling, especially in emergency situation, can help in reducing the intensity of the anger and frustration of the affected. Many respondents suggested that HCPs should be trained in techniques of de-escalating violence and counselling as that can effectively decrease violent incidents. Further, awareness campaigns on better understanding of emergency situation and respecting HCPs should be done so that behaviour of attendants may be improved.

Communication gap of HCPs with attendants of the patients was also reported as one of the major causes. It was suggested that HCPs should be trained in keeping the attendants and patients informed about the health status. Low competence of HCPs for provision of high quality care leads to mismanagement of patients and could be a major inciting factor of violence. Poor quality of services has also been previously reported as a major cause of violence among HCPs in a study conducted in Karachi.[7] This can be resolved through merit-based appointment and continuous capacity building of HCPs through trainings.

Poor availability of essential equipment, lack of medicines and less number of staff was also mentioned as a cause of violence by many respondents. Participants also pointed towards the lack of security personnel and equipment. Resource-related issues have also been reflected in previous studies.[8,12,14] The way forward for this is to conduct cost estimation exercises for resources required to deliver minimum standard of services and maintain adequate security levels.

Among institutional mechanisms, easy access of multiple attendants and delays in responding promptly to patients were seen as factors leading to violence against healthcare. There is a need of developing and implementing standard security policies in all hospitals, including triage, restriction of access of multiple attendants inside the hospital, zero tolerance warnings, weapon=free area notifications, and establishment of complaint cells. This can not only reduce mob violence but also help HCPs in providing better quality of care to the patients and ensure patient safety. Moreover, for field workers like vaccinators, community health workers and ambulance staff, trainings on field safety plans are also necessary. Further, to ensure early response of ambulance staff, amendment of traffic laws and awareness among people to give way to ambulance are required.

Major socio-political factors mentioned included lack of education, political indulgence in institutions, poor law and order, slow judicial system and corruption. This calls for continuous advocacy and lobbying for social reforms, especially aiming to attract more resources for health and prioritisation of health on legislative tables.

Experience of violence not only affects the individual, but also the family of the victim and his/her institution. It also demotivates them at their workplace with feeling of helplessness and depression. Violence reduces job satisfaction and affects the performance of victims. A study in Lebanon has also reported high tendency to quit job as a consequence of violence.[14] HCPs should be trained in managing post-traumatic stress in this regard and continuously reassured for complete institutional support in case of any event.

This study was conducted in Karachi with a limited number of respondents, which is a limitation in terms of generalisation of its findings and recommendations.

Conclusion

Violence faced by HCPs is a complex issue. There is a dire need to design interventions which can help in addressing the behavioural, institutional and socio-political factors promoting violence against HCPs. Future projects should focus on designing interventions to contain violence at multiple levels.

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